NHS Wales Joint Commissioning Committee

Strategy and Planning Maturity Self-Assessment

November 2026

Domain	Self-Assessment
Strategy Development/Clarity of Purpose, Vision and Strategy	3 – Results
Strategy Alignment and Development of an IMTP	2 – Early Progress
Dynamic & Engaged Planning	3 – Results
Operational Planning	2 – Early Progress
Best Practice Approach to Improvement	2 – Early Progress
Realistic & Deliverable	2 – Early Progress

Strategy Development/Clarity of Purpose, Vision and Strategy

A) Strategy Development/Clarity of Purpose, Vision and Strategy					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Strategy & Plan	No CSS or delivery plan in place but strategic framework for its development in development.	Draft CSS developed or in development.	Agreed CSS and development of a co-designed clinical services plan underway, with evidence of strong clinical, stakeholder and public engagement throughout. A patient led approach is evident.	Approved CSS and CSP. Implementation underway. Organisation actively identifies risks and opportunities, outcomes are regularly monitored, and planning is informed by data, horizon scanning, and cross-functional collaboration.	The organisation has a fully implemented CSS and CSP that is continuously reviewed and refined using real-time data and predictive insights. Regular strategic reviews (at least twice annually) are in place that enable flexible adjustments in response to emerging trends and priorities, in-year performance, and long-term opportunities. Strategic planning is agile, outcome-focused, and aligned with system-wide priorities, to maximise opportunities driving measurable improvements in performance and population health.
Vision & Purpose	Organisation is developing its vision and purpose. Clear outcomes are not yet defined.	Vision and purpose, scope and methodology agreed with clear commitment and leadership at a Board and strategy programme level. Clear outcomes are in development.	Organisational vision and purpose with defined outcomes are affirmed in public and internal documents. Organisation demonstrates proactive leadership at Executive and Board level.	Annual Board discussion takes place on organisational vision and purpose ensuring alignment with CSS and enabling plans, intended outcomes and the identification of risks/issues.	Have regular board debate, at least twice annually, on organisational vision and purpose, ensuring alignment with organisational actions, CSS, outcomes and performance and how in-year achievements, issues or opportunities impact on this. Organisation is able to flexibly adjust its CSS to maximise opportunities and remain responsive, outcome-focused, and future-ready.
Alignment of National Policy and All-Level partnership priorities	National policies and national, regional, local and partnership priorities are understood but are not yet translated into organisational strategies and plans.	National policies and national, regional and local priorities have been translated into strategic intent and agreed with stakeholders. WBFG Act and AHW are apparent and embedded in the agreed approach.	Organisational strategies and plans reflect national policies and national, regional and local health and partnership priorities. WBFG Act and AHW principles and integrated throughout.	Strategies and plans are regularly reviewed. They are aligned and responsive to national policy and legislation, and national/regional/local partnership priorities with clear links to the Regional Partnership Board and Public Service Boards.	Strategies and plans are regularly and proactively reviewed and aligned to emerging national policy and legislation, and local, regional and national partnership priorities. RPB's and PSB's are regularly engaged and involved in process. CSS outcomes demonstrate a contribution to the wider local economy, improved health and well-being and operational effectiveness.

Key Enablers	Key enablers—such as quality, safety, workforce, finance, digital technology, and research—are identified but not yet aligned to strategic planning. Their role in enabling delivery is recognised but not actively managed or coordinated.	Key enablers are identified, with plans underway to align them with the organisations overarching CSS. Quality expectations are defined, and initial steps taken to coordinate enabler contributions across programmes.	Key enablers are fully aligned with strategic objectives. Their potential is well understood and actively explored to support delivery. Quality expectations are clearly defined and embedded in planning processes, with enablers contributing to strategic coherence.	Key enablers underpin the development and delivery of the CSS and CSP. Opportunities linked to enablers are translated into actionable deliverables. Quality is integrated throughout the key enabling strategies and plans driving performance and improvement.	Key enablers are embedded across all strategic functions and are delivering measurable improvements and are considered best practice. Their impact is tracked through performance metrics, and they are continuously optimised to support innovation, agility, and system-wide transformation. Quality is not only integrated but drives strategic refinement and outcome achievement.
Engagement in Development	The duties of the Health and Social Care (Quality and Engagement) (Wales) Act (the Act) are identified as integral to the development and implementation of the CSS.	Engagement plans are in place to support the development of CSS.	Engagement plans are agreed and reflect strong clinical leadership. Plans meet the requirements of the Act	Plans are being implemented effectively with robust processes in place to capture diverse voices (internal and external) with strong clinical leadership, and where appropriate and necessary, offers opportunities for stakeholder involvement in shaping the development of CSS.	Organisation operates best practice and continuous engagement with both internal and external stakeholders, exemplifying the values seen in the quality and engagement act, ensuring voices from all communities are heard and reflected in the annual review of the CSS.
Population Health Needs Assessment	Plans are in place to undertake a population health needs assessment.	A basic high level population health needs assessment has taken place and is being used to shape the CSS.	CSS and CSP development is informed by population and health needs assessments and incorporates the wider determinants of health.	There is a single, detailed and regularly updated population health needs assessment in place. Strategies are updated regularly to clearly reflect the outcome of the assessment.	Population health needs assessment is recognised as best practice and is recognised and used by partner organisations (such as PSB and RPB) to form a common and shared understanding. CSS/CSP is regularly tested against current, emerging, and future population health needs.
Priorities & Achievability	The organisation does not have a prioritisation methodology or a recorded list of priorities. Planning is reactive and lacks strategic direction.	The organisation has an approved prioritisation framework related to population health needs assessment and has basic understanding of its priorities but is not yet reflected in plans. health needs.	A prioritisation framework is fully implemented. Priorities are recorded and aligned to population health needs assessments and Cabinet Secretary expectations. Early progress is made to reflect priorities in plans,	The organisation has a published, best-practice prioritisation methodology. It is fully aligned to population health needs and Cabinet Secretary expectations. Prioritised services are proactively reviewed and updated, with robust	Prioritisation is embedded across all planning and decision-making processes. The methodology is sector-leading based on the outcome of the population health needs assessment and Cabinet Secretary's expectations. It is co-produced with stakeholders, and continuously refined through evidence, evaluation, and engagement. Priorities are transparently linked to outcomes, resource

			with initial monitoring arrangements in place.	monitoring and governance of decisions embedded in planning cycles.	allocation, and national policy, with real-time monitoring and adaptive planning in place.
Horizon Scanning	Horizon scanning is infrequent and informal, with no structured process or discussion at Executive or Board level. Strategic planning is reactive, lacking foresight into emerging risks, trends, or opportunities.	Annual horizon scanning is conducted to identify key risks and opportunities. Findings begin to inform strategic thinking, but integration into planning and governance remains limited.	Horizon scanning is carried out regularly and used to test and validate strategic plans against future trends and risks. Insights are reviewed annually and inform planning cycles, with growing Board-level engagement.	Horizon scanning is embedded into strategic planning and governance processes. Findings are discussed at Board level annually, and strategies are actively validated and adjusted based on emerging insights. The organisation uses structured methods to anticipate change and mitigate risk.	Horizon scanning is systematic, forward-looking, and published. It informs biannual Board-level strategic discussions and enables flexible, data-driven adjustments to CSS. Insights are used to anticipate future scenarios, align with system-wide priorities, and ensure the organisation remains agile, resilient, and future-ready.

A) Strategy Development/Clarity of Purpose, Vision and Strategy Self-Assessment			
Domain	**Assessed level**	**Evidence Used**	**Any Supporting Narrative**
Strategy & Plan	**2**	Annual Plan 2026/27, sections 1.2, 2.2, 5 and 7.	The Annual Plan sets a coherent strategic framework and eight priority programmes, but the longer-term NWJCC strategy aligned to the national clinical services plan are still in development.
Vision & Purpose	**3**	Annual Plan, sections 1.1–1.2 and strategic objectives roadmap.	The NWJCC's vision, mission, values and five strategic objectives are explicit and used to structure the Plan. Evidence of regular review against outcomes is less developed.
Alignment of National Policy and All-Level partnership priorities	**3**	Annual Plan, sections 4–5.9; Planning Guidance Checklist, Appendix 8.	National priorities, the Planning Framework, Well-being of Future Generations Act, quality, equity and regional working are mapped into the Plan. The Annual Plan planning framework checklist identifies gaps, including explicit Marmot, women's health, QOF and audit references.
Key Enablers	**3**	Annual Plan, sections 3.8, 5.10–5.12 and 6; strategic objectives; QIA and EWLIA appendices; August 2026 Strategic Priorities Data Risk Analysis; October VESP update; Annual Plan Q2 Delivery Update.	Strategic objectives framed the Annual Plan, linking key enablers to delivery priorities. QIA and EWLIA processes were used to understand the consequences of decisions and inform planning. This supports level 3, recognising initial achievements in aligning enablers and considering quality and equality impacts. A stronger focus on outcomes is being developed within planning to make intended benefits and their measurement clearer. Consistent quantification of enabler requirements remains an area for development, with capacity, data and external dependencies continuing to constrain delivery.
Engagement in Development	**3**	Annual Plan, sections 3.3–3.6 and 5.1; QIA and EWLIA appendices; engagement plans used in key areas (e.g. EMRTS, Gender, Rural), including with diverse communities; regular meetings with Llais.	NWJCC does not hold statutory responsibility for consultation; this sits with Health Boards. Engagement plans have been used in key areas, particularly with diverse communities, alongside regular meetings with Llais. Health Boards, providers, clinicians and available patient feedback also informed the Plan. These arrangements support a best-fit level 3 assessment, without implying continuous co-production across all areas. Engagement must be creative and proportionate to the national commissioning role, working with Health Boards and Llais to capture local nuances and community perspectives that are

			difficult to replicate nationally. More consistent evidence of how this input shapes decisions remains an area for development.
Population Health Needs Assessment	**1**	Annual Plan, sections 5.7 and 5.2; recruitment of an Associate Medical Director in Public Health.	Commitment and supporting infrastructure are developing, but the evidence does not yet demonstrate a completed high-level population health needs assessment being used to shape strategy, as required for level 2. Existing service intelligence does not establish consistent assessment-led prioritisation. An agreed data catalogue, validated baselines, reliable access arrangements and named analytical capacity are needed. Level 1 recognises the planned assessment without implying that population evidence is absent from all current decisions.
Priorities & Achievability	**2**	Annual Plan, sections 2.2, 5.1–5.3 and 6.7; QIA Appendix 6; October VESP update; Annual Plan Q2 Delivery Update.	MoSCoW prioritisation, QIA scrutiny and explicit inclusions and exclusions provide a structured basis for transparent choices. Quarterly reporting strengthens oversight of priorities and achievability. However, consistent traceability from assessed population need to prioritisation decisions is not yet demonstrated, and data, capacity and external dependencies qualify deliverability. Level 2 is a best-fit judgement recognising this progress; full implementation and evidenced alignment to population health needs assessments are required for level 3.
Horizon Scanning	**3**	Annual Plan, sections 4.2, 5.12 and commissioning intentions.	Horizon scanning informs medicines, therapies and service planning, but evidence of a published, systematic process with regular Board review is limited.
Overall Judged Score	**3 – Results**	As above	Level 3 is a best-fit judgement reflecting initial achievements beyond a developing framework. The vision and strategic objectives frame the Annual Plan, national policy priorities are reflected in planning, and horizon scanning informs service priorities. QIA and EWLIA processes help assess the consequences of decisions, while engagement plans in key areas and regular Llais meetings support stakeholder input. The revised key enabler and engagement assessments strengthen this overall judgement; it is not an average of component scores. The longer-term strategy, population health needs assessment and clearer links between assessed need and priorities remain outstanding. More consistent outcome measurement and evidence of engagement influencing decisions are needed for level 4.

Strategy Development/Clarity of Purpose, Vision and Strategy Actions						
Domain	**Assessed level**	**Aspired Position**	**Action(s)**	**Timelines/Milestones**	**Evidence to be used**	**Impact Measurement**
Strategy & Plan	**2**	**3**	Complete and approve the NWJCC long-term strategy and translate it into a prioritised clinical services and commissioning delivery framework.	Draft by Mar 2027; engagement Apr–Jun 2027; approval by Sep 2027.	Approved strategy; clinical services and commissioning roadmap.	Strategy approved; all IMTP priorities mapped to outcomes, milestones and accountable leads.
Vision & Purpose	**3**	**4**	Embed outcomes as drivers of planning, prioritisation and commissioning decisions through the strategic planning and commissioning framework for the vision, mission and five strategic objectives and embed an annual Joint Committee review.	Outcomes agreed by May 2027; baselines by Jun 2027; first annual review by Mar 2028.	Strategic Planning and Commissioning framework; committee papers; performance reports.	All strategic objectives have baselines and measures; annual review leads to recorded decisions.
Alignment of National Policy and All-Level partnership priorities	**3**	**4**	Within our strategic planning and commissioning framework we will align national policy and partnership priorities.	Framework in place by Jan 2027; review regularly as part of the planning cycle.	Alignment matrix; partner feedback; IMTP cross-references; review log.	All material policies and partnership priorities mapped, with no unexplained gaps.
Key Enablers	**3**	**4**	Integrate, finance, digital, data, quality, research assumptions into strategic planning. Organisational development programme to bolster our skills capability and capacity	Skills gap analysis by end December 2026; business case for demand and capacity capability by end December 2026; programme of staff development developed by Mar 2027; regular review thereafter.	Enabler plans; programme dependencies; resource and risk assessments; costed workforce, digital and data requirements informing the internal demand and capacity modelling business case.	Strategic priorities have quantified enabler requirements, named owners and monitored dependencies.
Engagement in Development	**3**	**4**	Agree and sign off the NWJCC engagement protocol, distinguishing national engagement from Health Boards' statutory consultation responsibilities. Build on existing plans and regular Llais meetings, using creative, accessible approaches with	Protocol and proportionate engagement plan agreed by Feb 2027, including partner roles and locally tailored methods; first cycle reviewed by Jun 2027; annual evaluation. Continue regular Llais meetings throughout.	Signed-off protocol; engagement plans and learning reviews; Llais meeting records; agreed Health Board and community-partner roles; participation and local feedback records; "you said, we did" log; impact assessments; records of	Protocol approved with clear partner responsibilities. Review reach across diverse communities and localities, identify gaps and adapt methods. Decision records show how community and Llais feedback informed plans, with reasons recorded where

			Health Boards and community partners to reach diverse communities and capture local nuances. Record how feedback informs priorities, impact assessments and service reviews, applying the national substantial service change framework where relevant. Review learning from existing engagement plans to identify approaches that work nationally and those requiring locally tailored engagement.		national framework application where relevant.	proposals were not changed and responses shared with participants.
Population Health Needs Assessment	**1**	**3**	Produce a methodology for NWJCC population health needs assessment covering need, inequalities, demand, outcomes and the wider determinants, and apply it to shape strategic plans and commissioning priorities.	Workplan for AMD by Mar 2027; draft population health needs assessment methodology and overview by July 2027 to inform next planning cycle; approval and application by Sep 2027.	Approved assessment in targeted area; robust methodology; data catalogue; inequalities analysis; decision records.	All targeted commissioning priorities explicitly trace to assessed need and inequalities evidence.
Priorities & Achievability	**2**	**4**	Embed the prioritisation framework so decisions transparently link need, outcomes, quality, equity, affordability, deliverability and decommissioning implications.	Framework refreshed by Feb 2027; applied to 2027–30 priorities by Apr 2027; annual review.	Approved criteria; scored options; decision audit trail; affordability assessment.	All priorities pass agreed thresholds and have funded delivery routes or explicit escalation.
Horizon Scanning	**3**	**4**	Further develop our horizon-scanning processes to expand on existing processes to cover policy, technology, medicines, workforce, demand, finance, providers and service fragility, feeding formal strategic reviews.	Method by Jan 2027; first report by Mar 2027; Joint Committee review every six months.	Methodology; horizon reports; committee decisions; strategy change log.	Two reviews annually and clear evidence that emerging risks or opportunities alter plans.

Strategy and Plan Alignment, and Development of IMTP

B) Strategy and Plan Alignment, and Development of IMTP					
	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
IMTP Development	Organisation has an annual plan which responds to some but not all elements of planning framework and cannot provide a financially balanced plan over 3 years.	Organisation has an approved IMTP that aligns with the core elements of the planning framework. The plan demonstrates a structured approach to strategic priorities and is informed by baseline data. It includes initial consideration of risks, outcomes, and resource requirements.	IMTP meets almost all policy expectations and is tailored to deliver clear service transformation aligned with an agreed CSP and reflects a shift from operational delivery to strategic impact. Growing maturity in linking planning to measurable impact, return on investment, and strategic priorities. Risks are clearly identified, with evidence of controls and early mitigation strategies.	The IMTP meets all policy expectations and is consistently delivering against the quadruple aim and is embedded across the organisation and transforming services through the CSP. Risks across quality, access, workforce, and finance are actively managed with evidence of controls and mitigation and demonstrates clear alignment between planning, performance, and transformation.	The IMTP exceeds all national policy expectations. It is recognised as a benchmark for excellence, driving system-wide transformation and delivering sustained impact across the quadruple aim. The plan is co-produced, future-focused, and underpinned by robust evidence, innovation, and adaptive governance. It demonstrates clear and advanced triangulation, delivery timelines and milestones, and integrated risks and mitigation.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	Some alignment is visible between the annual plan and CSS with the organisation planning on a continuous annual cycle.	Alignment is clear and coherent between the IMTP and CSS with the organisation planning on a continuous annual cycle.	The IMTP is tailored to deliver clear service transformation in line with an agreed Clinical Services Plan. Plans are directly linked to quality, performance and accountability and informed by detailed and future facing modelling.	Coherent aligned plans, including a commissioning plan are performance managed, with staff owning, adapting, acting on and learning from variation.	Planning is owned by all staff and fully integrated and aligned across organisational tiers and system partners. There is a clear golden thread between local, national and regional strategies and partnerships with dynamic alignment to the CSS and Plan, IMTP, commissioning intentions, resulting from horizon scanning results, detailed population health needs assessment and enabling strategies (e.g. workforce, digital, estates).
Triangulation of Services	Basic high-level triangulation is taking place between services, activity, workforce and finance.	Clear triangulation between services, activity workforce and finance.	Detailed triangulation between services, activity workforce and finance at service level.	Clear detailed and robust triangulation and analysis of activity, workforce and finance which considers other holistic requirements such as	Triangulation is system-wide, predictive, and continuously refined through real-time data and advanced analytics. It informs strategic decision-making, resource optimisation, and service redesign across organisational boundaries. The organisation demonstrates a proactive approach

				training and working regionally.	to managing interdependencies, future workforce needs, financial sustainability, and service demand, with clear links to population health, regional collaboration, and innovation.
Commissioning	The Board sets out high level commissioning intentions primarily focused on statutory requirements and broad service categories. Commissioning is reactive, with limited strategic alignment or stakeholder engagement.	The organisation has an approved and operational commissioning process. Intentions begin to reflect service priorities and are informed by basic population health data and stakeholder input.	Commissioning decisions are prioritised based on service need, population health data, and performance metrics. The impact of commissioned and supporting organisations is actively considered.	The organisation has a clear, transparent commissioning plan that includes a transparent prioritisation framework and actions for both commissioning and decommissioning ensuring risk to patients are minimised. Decisions are evidence-based, responsive to changing needs and communicated effectively to stakeholders.	Commissioning is strategically embedded across the organisation and system, with clear alignment to the population health needs assessment, clinical priorities, and service transformation goals. The process is co-produced with stakeholders with a clear and transparent prioritisation framework, underpinned by robust evidence, and includes pro-active decommissioning where appropriate with detailed communication strategies. Commissioning decisions are transparent, equitable, and continuously evaluated for impact on quality, access, and outcomes.

Strategy and Plan Alignment, and Development of IMTP Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
IMTP Development	1	Annual Plan 2026/27; Appendix 8 Planning Guidance Checklist; Appendix 3 MDS; August 2026 Strategic Priorities Data Risk Analysis; IMTP 2027–30 Development Update, October 2026; October VESP update.	The current submission is an Annual Plan in a three-year context, not an approved IMTP. Level 1 therefore reflects the present planning position against this descriptor. Development of the 2027–30 IMTP is strengthening commissioning intentions, evidence-based prioritisation, strategic choices and engagement, supported by VESP progress. These are important foundations, but an approved IMTP, a credible sustainable three-year position and sustained benefits remain to be demonstrated. Satisfactory assessment of the Annual Plan does not meet the level 2 requirement for an approved IMTP.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	2	Annual Plan, sections 1.2, 2.2, 5.8 and 7.	Priorities align with emerging national and local clinical service planning, but the NWJCC strategy and national clinical services plan are not yet finalised.
Triangulation of Services	2	Annual Plan, sections 3, 5.3 and 6; MDS Appendix 3; October VESP update.	Activity, finance, quality and service pressures are triangulated at high level. Value, efficiency and sustainability work strengthens the link between resources and intended benefits, but consistent service-level integration remains limited by data quality, baselines and analytical capacity.
Commissioning	3	Detailed Commissioning Intentions, Appendix 2; Commissioned Services Directory, Appendix 1; IMTP 2027–30 Development Update, October 2026.	Commissioning intentions are being standardised and routed through proportionate pathways including prioritisation, recommissioning, strategic review, deep dive and routine commissioning. The process increasingly links population need, outcomes, equity, sustainability and whole-system value, although further evidence and leadership choices are required.
Overall Judged Score	2 – Early Progress	Annual Plan and Appendices 1–3 and 8.	The overall level 2 is a best-fit judgement across the domain, recognising developing strategic alignment, triangulation and stronger commissioning processes. It does not imply that the IMTP Development criterion is met: that component remains at level 1 because the current submission is an Annual Plan rather than an approved IMTP. Further maturity requires a sustainable three-year position, an approved IMTP and clearer alignment to an agreed strategy and clinical services plan.

Strategy and Plan Alignment, and Development of IMTP Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
IMTP Development	**1**	**3**	Develop an approvable three-year IMTP by bringing commissioning intentions, prioritisation, wider service and financial changes, fragile-service intelligence and strategic choices into one coherent plan with outcomes, milestones, resources and risks.	Prioritisation panel Nov 2026; strategic choices Nov–Dec 2026; draft plan Jan 2027; final plan Mar 2027.	IMTP; MDS; financial plan; delivery and assurance framework; priority data plans and consolidated data-risk log.	All Planning Framework requirements met and a balanced, credible three-year position submitted.
Alignment between Clinical Services Strategy and Plan and the IMTP or Annual Plan	**2**	**3**	Ensure that the JCC strategy and plan are dovetailed with the National Clinical Plan, health board local and regional plans and is reflected in our strategic priorities. It will be reflected in our strategic planning and commissioning framework.	Align strategic priorities with the National Clinical Plan and Health Board local and regional plans through the strategic planning and commissioning framework by Feb 2027; validate alignment and gaps with partners by Apr 2027; review quarterly as plans develop.	Strategic planning and commissioning framework; cross-references linking NWJCC strategic priorities and the IMTP to the National Clinical Plan and Health Board local and regional plans; partner validation records; governance decisions and alignment review log.	Every IMTP priority has a clear strategic source, outcome, owner and delivery measure.
Triangulation of Services	**2**	**3**	Introduce a standard service-level model through the strategic planning and commissioning framework triangulating need, activity, capacity, workforce, finance, quality, access and outcomes, starting with priority and fragile services. Pilot sustainability framework following workshop on 30 November 2026 around fragile services. Determine analytical and modelling capability to inform	Complete sustainability assessments by end December 2026 subject to data and resource decisions, with quarterly review to inform IMTP; assess analytical and modelling requirements by Dec 2026 to inform the capability business case;	Strategic planning and commissioning framework and service-level template; workshop outputs and sustainability pilot evaluation; validated service models, baseline and assumptions logs; scenario analysis; analytical capability assessment and business case; resource decisions and planning review records.	Track coverage of priority and fragile services with validated models linking need, activity, capacity, workforce, finance, quality, access and outcomes. Record how pilot findings and scenarios inform commissioning, investment and sustainability decisions; identify data and capability gaps, with named owners and agreed action through workforce planning.

			internal JCC workforce planning.			
Commissioning	**3**	**4**	Publish an integrated medium term plan with transparent prioritisation, outcome measures, available population-need links and proportionate decommissioning and communication arrangements.	Plan by March 2027; delivery plans by May 2027; quarterly outcome review.	IMTP and commissioning plans; prioritisation records; contracts; outcome dashboard.	All commissioning decisions evidence need, value, equity, affordability and measured outcomes.

Dynamic and Engaged Planning

C) Dynamic and Engaged Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Stakeholder Engagement	Staff and partners are aware of CSS/CSP and there is a public commitment in place to undertake stakeholder engagement.	Organisational engagement is evident in practice and reflected in the CSS/CSP. Broad engagement to inform Equality Impact Assessments and Socio-Economic Duty Assessments.	Stakeholders are engaged in and co-design priority setting using the 'engagement cycle' model and a person-centred approach. Staff engagement at an organisation level is increasing.	Full and proactive continuous engagement including diverse communities which informs, owns and tests all impact assessments. Feedback from engagement activities influences and challenges the plan. Planning is also embedded and co-ordinated throughout the organisation.	Internal continuous engagement sees a fully engaged and informed workforce who are able to co-produce. Feedback and learning from continuous engagement activities including protected characteristic groups and socio-economic disadvantaged groups informs local priority setting and the development of the CSS/CSP.
Service Delivery Risk and Issue Management Approach	Organisation has a service risk management approach in place, but it has not been fully adopted across all areas.	Organisation has service risk management approach embedded across all areas of the organisation and has robust plans in place to address / mitigate risks	A risk management approach is evident and consistent across organisation. The organisation stop fragile services are identified.	The risk management approach enables the early identification of fragile or soon to be fragile services allowing for early intervention to ensure service sustainability. Organisation sees less urgent service changes.	Potential fragile services identified early and robust risk management across organisation pre-emptively responding to emerging service risks and the organisation is able to flexibly adjust plan. The Board are informed and regularly updated on fragile services and organisation rarely sees urgent service changes.
Service Model / Regional Design	Organisation has no route, or route is ineffective to discuss potential opportunities or joint risks. Regional collaboration is minimal, ad hoc, and lacks strategic intent.	Strengthened partnership working arrangements are in place. A methodology for working together is developed, with early efforts to align priorities and build trust.	Opportunities for regional working and shared solutions are identified and developed collaboratively. Planning is increasingly aligned across organisations, with joint priorities and resource sharing.	Agreed proposals for robust regional service models (e.g. consolidation, shared services) are in place and delivery is underway. Governance structures support joint accountability and performance management.	Regional collaboration is fully embedded, strategically led, and continuously evolving. The organisation is a proactive system leader, driving the development, implementation, and optimisation of shared service models and regional solutions. Collaboration is underpinned by co-produced strategies, shared governance, and dynamic intelligence. The organisation anticipates future needs, fosters innovation, and delivers measurable improvements in equity, efficiency, and outcomes across the region.

Dynamic and Engaged Planning Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Stakeholder Engagement	**3**	Annual Plan, sections 3.3–3.6, 5.1 and 7; QIA workshop record; IMTP 2027–30 Communications and Engagement Plan; engagement plans in key areas, including with diverse communities; regular Llais meeting records. EWLIA appendix.	Structured engagement through Joint Committee, CCLG, CCDG, planning-to-planning and provider routes informs planning and impact assessment around key IMTP milestones. Alongside engagement plans in key areas, particularly with diverse communities, regular meetings with Llais and available patient feedback, this supports a best-fit level 3 assessment, consistent with Engagement in Development above. NWJCC's national engagement role is distinct from Health Boards' statutory consultation responsibilities. Creative, proportionate approaches with Health Boards, Llais and community partners are needed to capture local nuances that are difficult to replicate nationally. These initial achievements do not yet demonstrate consistent, person-centred co-design of priority setting through an engagement cycle across all areas. Organisational engagement and governance participation remain distinct from demonstrated co-production; more consistent evidence of how patient and community input shapes decisions is needed for further maturity.
Service Delivery Risk and Issue Management Approach	**3**	Annual Plan, sections 3.1–3.2, 5.5 and 8; QIA Appendix 6; IMTP 2027–30 Development Update and proposed fragile-services framework; October VESP update; Annual Plan Q2 Delivery Update; Joint Assurance Framework Report, September 2026; Leadership Forum risk-management discussion, 21 October 2026. Revised prioritisation process with risk modifier and more robust fragile services process, sustainability assessments	Directorate service risks, escalated organisational risks and strategic risks within the Joint Assurance Framework provide an established risk-management structure, supported by service-risk and delivery reporting. Level 3 recognises this approach and the identification of service fragility. It does not imply that proactive early-warning arrangements are fully embedded. More consistent escalation, earlier identification of emerging fragility and stronger two-way links with planning are required to demonstrate level 4.
Service Model / Regional Design	**3**	Annual Plan, sections 2.2, 5.6, 5.8 and 7; commissioning intentions.	National and regional reviews, Health Board sponsorship and collaborative governance provide active routes for shared solutions. Most models remain under review rather than fully implemented.

			Linking in with National Clinical Plan work to understand roles and responsibilities at national regional and local commissioning levels will strengthen our assessed level.
Overall Judged Score	**3 – Results**	Annual Plan and QIA.	Overall level 3 is a best-fit judgement reflecting initial achievements in stakeholder engagement, established service-risk oversight and collaborative development of national and regional service solutions. Stakeholder engagement is assessed at level 3, recognising structured input and engagement in key areas, while consistent person-centred co-design across all areas is not yet demonstrated. Progress beyond the current overall position requires deeper co-production, proactive fragility management and agreed service models moving into implementation.

Dynamic and Engaged Planning Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Stakeholder Engagement	**3**	**4**	Implement the agreed NWJCC engagement protocol and proportionate engagement plans through a mapped engagement cycle for priorities, impact assessments and service reviews. Distinguish national engagement from Health Boards' statutory consultation responsibilities; build on regular Llais meetings and work with Health Boards and community partners on creative, accessible methods that capture diverse voices and local nuances. Strengthen person-centred co-design and record how feedback informs decisions. Use learning from EMRTS and gender-service engagement and test approaches in rural communities, identifying what works nationally and what needs locally tailored engagement.	Protocol, stakeholder map and proportionate engagement plans agreed by Feb 2027, including partner roles, inclusion standards and locally tailored methods; first cycle reviewed by Jun 2027; annual evaluation. Continue regular Llais meetings throughout.	Signed-off protocol; stakeholder map and engagement plans; agreed Health Board and community-partner roles; Llais meeting records; co-design and participation records; local feedback and "you said, we did" log; impact assessments; learning reviews, including EMRTS, gender-service and rural engagement.	Review reach across diverse communities and localities, identify gaps and adapt methods. Record how stakeholder, community and Llais input shapes priorities, impact assessments, plans and service-review decisions, explaining where proposals are not changed and sharing responses with participants. Use learning to strengthen person-centred co-design.
Service Delivery Risk and Issue Management Approach	**3**	**4**	Embed consistent escalation across the three risk levels and two-way links between the Joint Assurance Framework and planning, supported by agreed risk appetite and early-warning indicators.	Apply strengthened EBRA through the Nov 2026 prioritisation panel; fragile-services workshop on 30 Nov 2026; sustainability assessments by end Dec 2026, subject to data and resource decisions, to inform the IMTP. Agree risk appetite	Assurance framework; risk appetite; service risk dashboard; escalation decisions.	Earlier identification and mitigation of fragility, with fewer unplanned urgent service changes.

			Embedding the strengthened approach to EBRA and fragile services sustainability assessments.	and escalation arrangements by Mar 2027; pilot early-warning indicators and integrate risk registers by Jun 2027; quarterly review thereafter.		
Service Model / Regional Design	**3**	**4**	Adopt a consistent gateway process for regional and national service reviews (learning from 2026/27 delivery of strategic priorities), with shared governance, option appraisal, resource implications and implementation accountability.	Process agreed by May 2027 as part of the delivery plan for IMTP; applied to active reviews from Jun 2027; annual evaluation.	Decision papers; option appraisals; partnership agreements; benefits plans.	Active reviews progress through agreed gateways and implemented models deliver stated equity, quality and efficiency benefits.

Operational Planning

D) Operational Planning

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Demand & Capacity Modelling	Basic demand and capacity work is undertaken and contains an appropriate level of detail to support service delivery	Demand and capacity planning undertaken at speciality level to support the design of current and future services. Data is more structured and used to inform service-level decisions	Robust and profiled projections of demand and capacity are used to inform the development of individual service plans, the Clinical Services Plan, and the IMTP. Planning is increasingly data-driven and cross-functional.	The organisation uses detailed and advanced modelling capability to support strategic planning. Demand and capacity modelling is embedded in the IMTP and informs transformation, workforce, and financial planning. Predictive analytics and AI tools support long-term planning.	Demand and capacity modelling including modelling projections is at the core of planning processes across the organisation. Predictive analytics and AI tools support long-term planning. Modelling triangulates resources, staff, finance and activity. It is able to undertake modelling at all levels of prevention and illustrates scenarios for improvement for the IMTP.
Clinical Leadership & Input	Clinical leads are identified and their roles are defined. Engagement is limited to basic consultation or information sharing	Clinical leads begin to inform service planning and contribute to performance improvement discussions. Their input is considered but not yet central.	Clinical leads are embedded early in the planning cycle to ensure that service design is clinically credible and patient-centred. Clinical leads co-produce plans and provide leadership in development processes. Their involvement is structured and increasingly strategic.	Clinical leadership is embedded in operational planning. Clinical teams actively shape service direction in alignment contributing to future direction services in line with clinical services plan.	Clinical leadership sits at the heart of planning and performance with a strong focus on quality and improvement. Clinical leaders co-produce plans and drive the future direction of plans through developing a culture of quality, innovation, and continuous improvement, fostering deep engagement and ownership across clinical teams.
Planning Process	Organisation has basic operational plans and planning process in place.	Operational plans are regularly reviewed and remedial action undertaken.	Operational plans have robust triangulation and modelling of plans based on a clear and consistent approach to demand and capacity modelling across the organisation	Coherent aligned and triangulated plans with clear links to CSS and CSP, including, with staff owning, adapting, acting on and learning from variation and inequity.	Operational plans are fully aligned and integrated into the development of IMTP and CSP. Staff own the process and act on opportunities and learning to improve holistic service provision and patient experience.

Operational Planning Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Demand & Capacity Modelling	**2**	Detailed Commissioning Intentions; Annual Plan sections 3.7, 5.11 and 6; MDS.	Demand, growth and capacity pressures are identified across services and inform financial assumptions. Modelling is not yet consistently profiled and integrated at specialty level across workforce, finance and activity. Inconsistent validation, data-access constraints, incomplete baselines, dependence on external support and insufficient analytical capacity remain key limitations. The internal demand-and-capacity modelling capability gap is recognised, with analytical and modelling requirements being assessed to inform workforce planning and a costed business case by end December 2026; strengthening capability remains subject to resource and funding decisions.
Clinical Leadership & Input	**3**	Annual Plan, sections 5.1, 5.12 and 7; QIA workshop; Commissioning Intentions and EBRA presentation (SLT 280926 – Final), slides 6 and 9–12.	Clinical input shaped prioritisation and QIAs and Associate Medical Directors are embedded in directorates. Clinically led evidence-based risk assessment (EBRA) will strengthen this level 3 assessment through evidence review, multidisciplinary panel scoring and risk-informed ranking to support Joint Committee decisions. Consistent application and demonstrable clinical influence across operational plans are needed for level 4; the proposed approach still requires testing and embedding.
Planning Process	**2**	Annual Plan, sections 5.1, 7 and Appendix 5; Annual Plan Delivery – Strategic Priority and Deep Dive Specifications, May 2026.	The planning cycle, governance and priorities are clear. Strategic priority scopes define deliverables, milestones, outcomes, risks, dependencies, leadership and stakeholders, providing a basis for consistent oversight; detailed operational plans remain necessary.
Overall Judged Score	**2 – Early Progress**	Annual Plan, commissioning intentions and MDS.	The operating framework is credible, with maturity constrained by incomplete detailed delivery planning and inconsistent demand-capacity triangulation.

Operational Planning Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Demand & Capacity Modelling	**2**	**3**	Assess internal analytical and modelling requirements and skills gaps to inform JCC workforce planning and a costed demand-and-capacity capability business case. Establish a common modelling standard through the strategic planning and commissioning framework, linking need, activity, capacity, workforce, finance, quality, access and outcomes, starting with priority and fragile services. Strengthen capability subject to resource and funding decisions.	Requirements assessment, skills gap analysis and costed business case by end Dec 2026; common standard within the developed by Jun 2027; staff development programme by Mar 2027. Confirm pilot and rollout milestones following resource and funding decisions; review quarterly alongside service triangulation and sustainability assessments.	Capability and skills gap assessment; workforce and staff development plans; costed business case and options appraisal; recorded resource and funding decisions; framework and common modelling standard; data catalogue and access agreements; baseline and assumptions; scenario outputs; sustainability assessments and planning decisions.	Requirements and skills gaps inform workforce planning and a submitted business case, with resource decisions recorded. Subject to agreed investment, track internal modelling capacity, priority and fragile-service model coverage, forecast accuracy and reliance on external support against validated baselines. Record how modelling informs commissioning choices, service plans and sustainability decisions, with named owners for remaining gaps.
Clinical Leadership & Input	**3**	**4**	Formalise clinical leadership expectations across the planning cycle, ensuring early co-production, documented challenge and clinical ownership of outcomes. Test and refine the clinically led EBRA approach, then embed agreed scoring and risk assessment in commissioning prioritisation and planning.	Roles and standards by Jan 2027; embedded in 2027–30 cycle; review by Sep 2027.	Role descriptions; attendance and sign-off records; clinical advice logs. Approved EBRA methodology; pilot evaluation; clinical panel records; completed evidence reviews and scoring; decision records linking recommendations to commissioning priorities and plans.	All priority plans have named clinical leads and documented evidence of clinical influence. Eligible proposals consistently use the tested EBRA approach, with documented clinical influence on priorities and decisions. Any departures from recommendations are explained, and agreed priorities translate into delivery plans with monitored outcomes.
Planning Process	**2**	**3**	Complete the delivery plan and operate a co-ordinated planned approach linking strategy, commissioning, finance, workforce, performance, risk and review. by embedding the strategic planning and commissioning framework.	Delivery plans by May 2027; monthly monitoring from Jun 2027.	Approved delivery plan; planning cycle timeline; highlight reports; action logs.	All priorities have owners, milestones, outcomes and current status; slippage triggers timely corrective action.

E) Best Practice Approach to Improvement

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Engagement	Engagement is minimal and reactive. Feedback is collected from patients and staff, but there is no structured approach to measuring the effectiveness of engagement activities or approach. Insights are rarely used to inform decision-making.	The organisation has a visible commitment to best practice, supported by training and an improvement strategy. Engagement with national programmes is active, and structured methods for collecting feedback and measuring impact are in place, though not yet fully embedded.	Organisation is developing an engagement strategy/plan and is proactive in identifying and learning from best practice in engagement to ensure voices are captured from all stakeholders especially clinical, minority and diverse voices.	Engagement is embedded across all organisational activities—planned and unplanned. The engagement strategy ensures robust inclusion of diverse and clinical voices, supported by strong data collection and analysis. Feedback directly informs action, driving continuous improvement.	Stakeholder engagement is transformational—co-designed and co-led by patients, staff, and communities. Real-time feedback tools enable adaptive responses, while inclusive practices ensure diverse voices shape decisions. The organisation is nationally recognised for its leadership in engagement, with a clear link between stakeholder input and measurable improvements
Benchmarking	Organisation is beginning to explore value-based healthcare principles, but planning remains reactive and output-focused. Benchmarking is ad hoc, with limited structure or consistency. There is minimal understanding of how comparative data can drive improvement, and benchmarking is not yet linked to strategic goals.	Value-based planning is gaining traction, and regular benchmarking is conducted with other NHS organisations. The organisation begins to use structured benchmarking methods to identify best practice, though application is inconsistent. Staff awareness is growing, and benchmarking is starting to inform service reviews and improvement discussions.	Benchmarking processes are formalised, consistently applied, and span across Wales and the UK. The organisation uses comparative data to identify performance gaps and inform strategic planning. Benchmarking is aligned with value-based healthcare principles, and results are used to prioritise improvement initiatives. Staff are engaged in interpreting data and applying insights to their areas.	Benchmarking is fully integrated into planning and performance cycles. Staff across the organisation actively lead benchmarking and improvement initiatives, using data to drive decisions and measure impact. There is a strong culture of ownership and continuous learning. Benchmarking includes qualitative and quantitative measures, peer comparisons, and outcome-focused metrics aligned with patient value. Insights are shared across teams and used to scale best practice.	Demonstrates full integration of benchmarking and value-based planning across strategic, operational, and clinical areas. Advanced analytics, including predictive and real-time data, drive proactive improvements and innovation. Recognised as a leader in the NHS, the organisation shapes best practice while fostering a culture where staff lead continuous improvement and scalable innovation.
Governance	Governance arrangements are informal, fragmented, or unclear. Oversight of IMTP development is minimal, with limited	A governance structure has been established to provide direction and oversight for IMTP	A formal governance and accountability framework is in place for IMTP development and	Governance is embedded across the organisation, with a mature CSS and oversight mechanisms that are	Governance is fully integrated, agile, and strategically aligned across all levels. Oversight of the IMTP, CSS and CSP is co-produced with clinical leaders and stakeholders, supported by

	accountability, transparency, or alignment to strategic priorities. There is no structured process for risk management, stakeholder involvement, or performance monitoring.	development. Roles and responsibilities are defined, and basic reporting mechanisms are in place. There is growing awareness of the need for structured governance, but integration with programme-level planning and delivery is still emerging.	monitoring at programme level. IMTP and CSS/CSP governance is aligned with strategic objectives, includes defined escalation routes, and supports performance tracking. IMTP Governance is periodically tested for improvements.	reviewed annually for relevance and effectiveness. IMTP and CSS/CSP governance structures support cross-functional collaboration, robust data use, and continuous improvement. Governance is constantly and pro-actively tested for improvements.	real-time data, predictive analytics, and dynamic risk intelligence. IMTP/CSS/CSP governance structures are benchmarked against national best practice, continuously refined, and used to drive innovation, accountability, and system-wide impact. Decision-making is transparent, inclusive, and outcome-focused.

Best Practice Approach to Improvement Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Engagement	**3**	Annual Plan, sections 3.3–3.6 and 5.5; QIA workshop record; EWLIA Appendix 7; IMTP 2027–30 Communications and Engagement Plan; engagement plans in key areas, including with diverse communities; regular Llais meeting records; EMRTS and rural engagement experience.	Multiple stakeholder routes inform planning, quality and equality assessment. Engagement plans in key areas, particularly with diverse communities, and regular Llais meetings support a best-fit level 3 assessment, consistent with the earlier sections. Existing engagement experience provides a basis for learning and strengthening the organisation-wide protocol and proportionate plans. NWJCC's national engagement role is distinct from Health Boards' statutory consultation responsibilities; creative, accessible approaches with Health Boards and community partners are needed to capture local nuances. Continuous engagement and consistent co-production across all areas are not yet demonstrated. More systematic evaluation of reach, inclusion and how feedback changes decisions is needed for level 4.
Benchmarking	**2**	Annual Plan, sections 5.4, 5.6 and 5.11; service deep dives and commissioning intentions.	Benchmarking informs value-based reviews, contracting, performance work and service deep dives. This supports level 2, with structured comparative analysis beginning to influence improvement. However, consistent application across the portfolio and use of Wales and UK comparators are not yet demonstrated to the standard required for level 3. Further access to Model Health and analytical tools is planned; a formal programme and evidence of resulting improvement remain development priorities. Linking in with P&I
Governance	**3**	Annual Plan, sections 5.1, 7 and 8; Joint Committee and sub-committee oversight.	Formal Joint Committee, CCLG, executive sponsorship, SRO and PMO arrangements are defined. The effectiveness of governance and delivery assurance has not yet been demonstrated over a sustained cycle.
Overall Judged Score	**2 – Early Progress**	Annual Plan and impact assessments.	Overall level 2 remains a best-fit judgement reflecting developing improvement practice. Engagement and governance are assessed at level 3, while benchmarking remains at level 2 – Early Progress. These stronger component assessments do not by themselves demonstrate consistent improvement practice across the domain; the overall judgement is not an average of component scores. Progress to overall level 3 requires more systematic benchmarking and clearer evidence that inclusive engagement and comparative insights shape priorities and improvement actions.

Best Practice Approach to Improvement Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Engagement	**3**	**4**	Agree and implement the NWJCC engagement protocol and proportionate engagement plans, with standards for inclusion, feedback analysis, co-production and evaluation of influence. Distinguish national engagement from Health Boards' statutory consultation responsibilities. Build on existing plans and regular Llais meetings, working with Health Boards and community partners on creative, accessible methods that capture diverse voices and local nuances. Use learning from existing engagement to improve practice.	Protocol, stakeholder map and proportionate engagement plans agreed by Feb 2027, including partner roles, inclusion standards and locally tailored methods; first cycle reviewed by Jun 2027; annual evaluation. Continue regular Llais meetings throughout.	Signed-off protocol; stakeholder map and engagement plans; agreed Health Board and community-partner roles; Llais meeting records; participation and co-design records; feedback database and "you said, we did" log; impact assessments; evaluation framework, learning reviews and improvement actions.	Review engagement reach and inclusion across diverse communities and localities, identify gaps and adapt methods. Record examples of community, stakeholder and Llais feedback shaping priorities, impact assessments, plans and service changes. Explain where proposals are not changed, share responses with participants and use evaluation to strengthen co-production and improve engagement practice.
Benchmarking	**2**	**4**	Strengthen benchmarking using NHS Wales, UK and value-based comparators, embedded in service reviews and improvement plans. Working with NHS Wales P&I and DHCW to ensure the available data is accessible.	Priority metrics by Jul 2027; baseline by Sept 2027; six-monthly review thereafter.	Benchmark dashboards; peer comparisons; deep dives; improvement plans.	All priority services have comparators and close agreed performance or outcome gaps.
Governance	**3**	**4**	Use the Annual Plan Development audit findings and agreed recommendations to inform improvements.	Review by Mar 2027; update framework as required by Jun 2027; annual effectiveness review. Track agreed audit actions to approved deadlines.	Strategic Planning and Commissioning framework; Planning and PMO remit; decision and escalation logs; audit report and agreed action plan; effectiveness review.	Clear responsibilities, timely decisions and closure of assurance gaps and audit actions, with lessons informing the 2027–30 IMTP.

Realistic & Deliverable

F) Realistic & Deliverable

	1 - Basic Level Principle accepted and commitment to action	2 - Early Progress Early progress in development	3 - Results Initial achievements	4 - Maturity Results consistently achieved	5 - Exemplar Others learning from our consistent achievements
Risk Identification & Management	Risk identification and management are inconsistent and reactive. Risks to IMTP delivery are not systematically captured or monitored. There is limited ownership or visibility of delivery risks.	A formal risk management process exists and is applied to IMTP delivery at a high level. Risks are identified at the planning stage and tracked through basic registers and reviewed periodically. Ownership is clearer, but integration with delivery assurance is limited. Escalation processes in place but not always followed.	Risk identification and management are embedded in IMTP development and delivery processes. Risks are identified early and linked to specific objectives, milestones, and outcomes. Controls are monitored, and mitigation actions are tracked. Risk registers are dynamic and inform delivery with clear ownership.	Risk management is proactive, strategic, and forward-looking with an agreed and clear risk appetite. Risks are anticipated and identified through horizon scanning, sensitivity analysis and scenario planning. The organisation adapts delivery plans in response to emerging risks with regular reviews. Lessons learnt informs future IMTP cycles.	Risk management is fully embedded across the organisation and system partners and is triangulated across workforce, finance, digital and clinical lenses. It is predictive, real-time, and continuously informs IMTP delivery through live dashboards and predictive analysis. The organisation leads in using risk intelligence to drive improvement, resilience, and transformation. The organisation operates continuous learning and is recognised for excellence in risk-informed delivery assurance.
Development of IMTP and track record	The organisation has a track record of submitting annual plans that do not meet the requirements of the planning framework, Cabinet Secretary expectations or provide a financially balanced plan over 3 years. Planning is largely operational and short-term, with limited strategic integration and has limited clinical or financial planning alignment and limited stakeholder engagement.	The organisation consistently develops robust annual plans that build assurance as a key step toward an approvable IMTP. Plans begin to reflect medium term priorities, include a finance and delivery framework, and show early signs of strategic alignment including financial forecasts and delivery milestones.	The organisation has developed an approvable, outcomes-focused IMTP that reflects strategic priorities, enabling plans and clinical service plans. A robust 3-year sustainable financial plan is included, with clear links to service transformation (with milestones and timelines) with clearly articulated risks and mitigations.	The organisation has a history of submitting high quality IMTP's that are strategically integrated and includes a comprehensive delivery and assurance framework. It demonstrates alignment across all enabling strategies and is informed by detailed modelling, population health intelligence, and with significant stakeholder input.	The organisation is recognised for excellence in IMTP delivery and assurance and has a long history of developing and submitting high quality IMTP's which surpass policy expectations and is recognised as a system-leading exemplar. It is co-produced and informed by detailed analysis and predictive tools to drive transformation across the health system, delivers the quadruple aim.
Monitoring and Delivery	Monitoring of annual plan or IMTP delivery is ad hoc and reactive and focused on immediate operational issues. There is limited visibility of progress, and reporting is inconsistent.	The organisation has a structured approach to monitoring annual plan or IMTP delivery with ownership of delivery emerging across services.	Monitoring of IMTP delivery is consistently seen as business as usual and integrated with performance management reviews and	IMTP delivery is monitored through a robust, outcome-focused framework which includes impact evaluation. The organisation adapts delivery plans based on	IMTP monitoring and delivery are embedded in real-time, system-wide performance and governance structures. The organisation demonstrates strategic leadership in delivery assurance, advanced triangulation, using predictive analytics, scenario planning, and co-

	Accountability is unclear and delivery risks are not systematically managed.	Key milestones and actions are tracked, and reporting mechanisms are in place through basic dashboards and reported to the Board regularly. Accountability is improving, but integration with performance and risk management is limited.	risk assurance processes. Progress is tracked against outcomes, and corrective actions are taken. Delivery is supported by enabling functions and aligned with strategic priorities. Delivery is starting to inform future planning.	performance insights, emerging risks, and system pressures. Staff are engaged in owning and delivering IMTP priorities.	produced improvement plans. Delivery is continuously optimised to achieve the quadruple aim. Continuous improvement cycles are embedded, with clear evidence of impact and the

Realistic & Deliverable Self-Assessment

Domain	Assessed level	Evidence Used	Any Supporting Narrative
Risk Identification & Management	**4**	Annual Plan, sections 3.1–3.2 and 8; QIA Appendix 6; August 2026 Strategic Priorities Data Risk Analysis and RAID log; October VESP update; Annual Plan Q2 Delivery Update; Joint Assurance Framework Report, September 2026; Leadership Forum risk-management discussion, 21 October 2026; Risk Management and Assurance paper, 21 July 2026, and Appendices 1–6: Risk Management Procedure, Joint Committee Assurance Framework (JAF), strategic-risk reporting template, proposed strategic risks, Risk Appetite Statement and Matrix (supplied final drafts).	Level 4 is the best-fit judgement, reflecting the agreed Risk Appetite Statement and Matrix alongside established strategic and operational risk oversight. Planning, RAID logs and delivery reporting demonstrate active risk and mitigation tracking. Commissioner-specific scoring, defined ownership and escalation between directorate registers, the Organisational Risk Register and JAF link risks to strategic objectives, performance and clinical escalation. The strategic-risk suite covers finance, quality and outcomes, service fragility, data and analytical capacity, commissioning accountability and the ambulance model. Reporting arrangements capture controls, assurance gaps, mitigating actions, intended impact and success indicators. Together with horizon scanning and regular delivery reviews, these arrangements support a proactive, forward-looking approach rather than basic risk tracking. Capacity, data and system dependencies remain constraints. Further improvement should strengthen consistent application of the agreed risk appetite, links to delivery milestones and outcomes, and the use of scenario and sensitivity analysis to adapt plans and inform future IMTP cycles. The level 4 judgement does not imply that predictive, real-time risk management is fully embedded across the system.
Development of IMTP and track record	**2**	Annual Plan 2026/27 and Planning Guidance Checklist; October VESP update; Annual Plan Q2 Delivery Update; NHS Wales Chief Executive letter, 22 October 2026, including Annex 1 accountability conditions.	The NHS Wales Chief Executive's letter of 22 October 2026 confirms the Annual Plan 2026/27 was assessed as satisfactory, strengthening the emerging planning track record. VESP and Q2 progress provide further support, but this is not approval of a three-year IMTP. Delivery of the accountability conditions and sustained outcomes remain to be demonstrated; level 2 remains appropriate.
Monitoring and Delivery	**3**	Annual Plan, sections 3.7, 5.4, 5.11 and 7; Strategic Priority and Deep Dive Specifications, May 2026; October VESP update; Annual Plan Q2 Delivery Update.	Defined sponsorship, delivery leadership and PMO arrangements are present. Highlight and quarterly reporting strengthen oversight of priorities, confidence and exceptions. Value, efficiency and sustainability assurance is progressing, although consistent benefits

			validation and outcome-based reporting can be strengthened.
Overall Judged Score	**2 – Early Progress**	Annual Plan, QIA and Planning Guidance Checklist; October VESP update; Annual Plan Q2 Delivery Update.	Overall level 2 – Early Progress remains a best-fit judgement, rather than an average of component scores. Risk Identification & Management is assessed at level 4, Monitoring and Delivery at level 3, and Development of IMTP and track record at level 2. Value, efficiency and sustainability progress and Q2 delivery reporting strengthen the assessment. Reasonable assurance on progress is balanced by cautious delivery confidence, capacity constraints and benefits still requiring validation. These support retaining the overall score at level 2 despite the stronger risk-management and monitoring assessments.

Realistic & Deliverable Actions

Domain	Assessed level	Aspired Position	Action(s)	Timelines/Milestones	Evidence to be used	Impact Measurement
Risk Identification & Management	**4**	**4**	Sustain level 4 by consistently applying the agreed risk appetite and existing escalation arrangements. Validate JAF ownership, scores, target tolerances, controls and assurances; give assurance gaps time-bound actions and success measures. Link directorate and organisational risks to strategic risks, IMTP milestones and outcomes through the planning and commissioning framework. Strengthen horizon scanning, scenario and sensitivity analysis and record resulting plan changes and lessons. Retain data-risk tracking of validation, access, baselines, external dependencies and analytical capacity; address training and assurance-effectiveness gaps.	Risk appetite agreed; validate JAF completeness and improvement actions by Jan 2027 alongside the planning framework. Apply scenario testing to the Mar 2027 IMTP; review register links, training needs and assurance effectiveness by Jun 2027. Review risks at procedure-defined frequencies and report JAF each Joint Committee cycle; quarterly planning deep dives and annual review of appetite, procedure and strategic risks.	Agreed Risk Appetite Statement and Matrix; Risk Management Procedure; populated JAF reports and linked registers; named owners, scoring rationales and target tolerances; control testing and assurance-gap action plans; committee scrutiny and escalation decisions; horizon scans, scenario and sensitivity outputs; IMTP change and lessons logs; data-risk dashboard and RAID log; training records and annual effectiveness review.	Major delivery risks have named owners, current scores, evidenced controls, target tolerances and time-bound mitigations. Track review timeliness, overdue actions and closure of assurance gaps. Risks outside appetite receive recorded treatment or authorised escalation. Show how scenarios and risk reviews change priorities, resources or delivery plans, and how lessons inform subsequent IMTP cycles; test mitigation effectiveness rather than relying on action completion alone.
Development of IMTP and track record	**2**	**3**	Build a credible three-year IMTP and delivery track record.	Draft IMTP by Mar 2027; national submission to timetable.	22 October 2026 letter and Annex 1; accountability-condition tracker; IMTP and financial plan; quarterly submissions and refreshed MDS; Joint Committee scrutiny and risk decisions; publication records; Accountable Officer letters where required; benefits records.	Plan is approvable and sustainable, with at least 90% of milestones achieved or recovered to plan. Accountability conditions show evidenced progress against agreed milestones; quarterly returns and MDS are complete and timely, adverse variances prompt corrective action, and publication and material-change requirements are met.

Monitoring and Delivery	**3**	**3**	Introduce and implement an outcome based strategic planning and commissioning framework combining SMART milestones, benefits, finance, quality, workforce, performance and risk in one reporting cycle. Include data quality, access, baselines, analytical capacity and external dependencies, with named owners and escalation.	Framework by Jan 2027; dashboard by Apr 2027; monthly review and quarterly Joint Committee assurance.	Delivery dashboard; highlight reports; benefits register; corrective action and decision logs; data-risk dashboard covering validation, access, baselines, capacity and dependencies.	Complete monthly reporting, timely escalation and sustained improvement in milestone and outcome delivery.